		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042861

Facility Name: PROVENA VILLA FRANCISCAN

Address: 210 N. SPRINGFIELD (Number) JOLIET (City) 60435 (Zip Code)

County: WILL

Telephone Number: (815) 725-3400 **Fax #** (815) 725-2160

IDPA ID Number: 371127787008

Date of Initial License for Current Owners: 12/01/97

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 (c3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Lynda Olinski **Telephone Number:** (708) 478-7916

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Michael R. Gordon
(Title) VP of Finance, CFO

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number PROVENA VILLA FRANCISCAN # 0042861 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	136	Skilled (SNF)	136	49,776	1
2		Skilled Pediatric (SNF/PED)			2
3	40	Intermediate (ICF)	40	14,640	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	176	TOTALS	176	64,416	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	25,706	893	12,418	39,017	8
9	SNF/PED					9
10	ICF		19,578		19,578	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,706	20,471	12,418	58,595	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.96%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A - None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 9/1/1990

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/1/1997 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 46 and days of care provided 12,418

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PROVENA VILLA FRANCISCAN # 0042861 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	352,451	35,624	31,961	420,036		420,036		420,036			1
2	Food Purchase		327,012		327,012		327,012	2,750	329,762			2
3	Housekeeping	173,128	47,924	510	221,562		221,562		221,562			3
4	Laundry	47,355	14,251	103,811	165,417		165,417	(33,610)	131,807			4
5	Heat and Other Utilities			179,684	179,684		179,684	1,396	181,080			5
6	Maintenance	145,413	7,978	53,812	207,203		207,203	50,622	257,825			6
7	Other (specify):* Pastoral Care/Develop	49,225	743	9,699	59,667		59,667	(24,376)	35,291			7
8	**TOTAL General Services**	767,572	433,532	379,477	1,580,581		1,580,581	(3,218)	1,577,363			8
	B. Health Care and Programs											
9	Medical Director			22,704	22,704		22,704		22,704			9
10	Nursing and Medical Records	3,424,270	317,134	444,930	4,186,334		4,186,334		4,186,334			10
10a	Therapy			526,296	526,296		526,296		526,296			10a
11	Activities	147,445	5,445	28,800	181,690		181,690	2,450	184,140			11
12	Social Services	87,928		1,443	89,371		89,371		89,371			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,659,643	322,579	1,024,173	5,006,395		5,006,395	2,450	5,008,845			16
	C. General Administration											
17	Administrative	312,999	1,455	839,247	1,153,701		1,153,701	(437,599)	716,102			17
18	Directors Fees											18
19	Professional Services			93,568	93,568		93,568	362,696	456,264			19
20	Dues, Fees, Subscriptions & Promotions			55,851	55,851		55,851	14,613	70,464			20
21	Clerical & General Office Expenses		17,528	43,155	60,683		60,683	(6,042)	54,641			21
22	Employee Benefits & Payroll Taxes			1,111,631	1,111,631		1,111,631	131,683	1,243,314			22
23	Inservice Training & Education			9,761	9,761		9,761	9,209	18,970			23
24	Travel and Seminar			6,715	6,715		6,715	8,110	14,825			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			90,433	90,433		90,433	9,063	99,496			26
27	Other (specify):* Bad Debt			150,000	150,000		150,000	(82,811)	67,189			27
28	**TOTAL General Administration**	312,999	18,983	2,400,361	2,732,343		2,732,343	8,922	2,741,265			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,740,214	775,094	3,804,011	9,319,319		9,319,319	8,154	9,327,473			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PROVENA VILLA FRANCISCAN #0042861 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			345,997	345,997		345,997	126,150	472,147			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							212,175	212,175			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							17,860	17,860			34
35	Rent-Equipment & Vehicles			72,611	72,611		72,611	1,810	74,421			35
36	Other (specify):* Loss on Asset Disposals			7,585	7,585		7,585		7,585			36
37	**TOTAL Ownership**			426,193	426,193		426,193	357,995	784,188			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			795,439	795,439		795,439		795,439			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			96,624	96,624		96,624		96,624			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			892,063	892,063		892,063		892,063			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,740,214	775,094	5,122,267	10,637,575		10,637,575	366,149	11,003,724			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PROVENA VILLA FRANCISCAN # 0042861 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(33,610)	4		8
9	Non-Straightline Depreciation	12,370	30		9
10	Interest and Other Investment Income	(8,411)	32		10
11	Discounts, Allowances, Rebates & Refunds	(18,342)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(150,000)	27		24
25	Fund Raising, Advertising and Promotional	(8,351)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (206,344)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	597,948		34
35	Other- Attach Schedule	(25,455)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 572,493		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 366,149		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

PROVENA VILLA FRANCISCAN

ID# 0042861

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Development Salares	$ (14,461)	7	1
2	Development Activities/Fundraising	0	7	2
3	Development Miscellaneous	(9,915)	7	3
4	Development Benefits	(1,079)	22	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(25,455)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PROVENA VILLA FRANCISCAN # 0042861 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	2,750	0	0	0	0	0	0	0	0	0	2,750	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(33,610)	0	0	0	0	0	0	0	0	0	0	(33,610)	4
5	Heat and Other Utilities	0	1,396	0	0	0	0	0	0	0	0	0	1,396	5
6	Maintenance	0	498	50,124	0	0	0	0	0	0	0	0	50,622	6
7	Other (specify):*	(24,376)	0	0	0	0	0	0	0	0	0	0	(24,376)	7
8	**TOTAL General Services**	(57,986)	4,644	50,124	0	0	0	0	0	0	0	0	(3,218)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	2,450	0	0	0	0	0	0	0	0	0	2,450	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	2,450	0	0	0	0	0	0	0	0	0	2,450	16
	C. General Administration													
17	Administrative	0	(392,685)	(44,914)	0	0	0	0	0	0	0	0	(437,599)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	37,372	325,324	0	0	0	0	0	0	0	0	362,696	19
20	Fees, Subscriptions & Promotions	(8,351)	22,964	0	0	0	0	0	0	0	0	0	14,613	20
21	Clerical & General Office Expenses	(18,342)	12,300	0	0	0	0	0	0	0	0	0	(6,042)	21
22	Employee Benefits & Payroll Taxes	(1,079)	59,493	73,269	0	0	0	0	0	0	0	0	131,683	22
23	Inservice Training & Education	0	9,209	0	0	0	0	0	0	0	0	0	9,209	23
24	Travel and Seminar	0	8,110	0	0	0	0	0	0	0	0	0	8,110	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	9,063	0	0	0	0	0	0	0	0	0	9,063	26
27	Other (specify):*	(150,000)	0	67,189	0	0	0	0	0	0	0	0	(82,811)	27
28	**TOTAL General Administration**	(177,772)	(234,174)	420,868	0	0	0	0	0	0	0	0	8,922	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(235,758)	(227,080)	470,992	0	0	0	0	0	0	0	0	8,154	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **PROVENA VILLA FRANCISCAN** **#** **0042861** **Report Period Beginning:** **01/01/04** **Ending:** **12/31/04**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	12,370	0	113,780	0	0	0	0	0	0	0	0	126,150	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,411)	0	220,586	0	0	0	0	0	0	0	0	212,175	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	17,860	0	0	0	0	0	0	0	0	17,860	34
35	Rent-Equipment & Vehicles	0	0	1,810	0	0	0	0	0	0	0	0	1,810	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	3,959	0	354,036	0	0	0	0	0	0	0	0	357,995	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(231,799)	(227,080)	825,028	0	0	0	0	0	0	0	0	366,149	45

Facility Name & ID Number PROVENA VILLA FRANCISCAN # 0042861 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	$	Provena Senior Services	100.00%	$ 2,750	$ 2,750	1
2	V	5	Utilities		Provena Senior Services	100.00%	1,396	1,396	2
3	V	6	Maintenance - Other		Provena Senior Services	100.00%	498	498	3
4	V	11	Activities-Special Events		Provena Senior Services	100.00%	2,450	2,450	4
5	V	17	Admin - Misc. Other	592,323	Provena Senior Services	100.00%	5,822	(586,501)	5
6	V	17	Administrative Salaries		Provena Senior Services	100.00%	193,816	193,816	6
7	V	19	Professional Services		Provena Senior Services	100.00%	37,372	37,372	7
8	V	20	Dues,Subscriptions		Provena Senior Services	100.00%	22,964	22,964	8
9	V	21	Clerical Supplies		Provena Senior Services	100.00%	12,300	12,300	9
10	V	22	Employee Benefits		Provena Senior Services	100.00%	59,493	59,493	10
11	V	23	Education/Conference		Provena Senior Services	100.00%	9,209	9,209	11
12	V	24	Travel		Provena Senior Services	100.00%	8,110	8,110	12
13	V	26	Insurance		Provena Senior Services	100.00%	9,063	9,063	13
14	Total			$ 592,323			$ 365,243	$ * (227,080)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROVENA VILLA FRANCISCAN # 0042861 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		27	Bad Debt	$	Provena Senior Services	100.00%	$ 67,189	$ 67,189	15
16	V		30	Depreciation		Provena Senior Services	100.00%	3,660	3,660	16
17	V		32	Interest		Provena Senior Services	100.00%	220,586	220,586	17
18	V		34	Rent - Facility		Provena Senior Services	100.00%	17,860	17,860	18
19	V		35	Rent - Equipment		Provena Senior Services	100.00%	1,810	1,810	19
20	V		17	Admin Salaries	146,040	Provena Health Services	100.00%	94,657	(51,383)	20
21	V		22	Employee Benefits		Provena Health Services	100.00%	34,293	34,293	21
22	V		30	Depreciation		Provena Health Services	100.00%	110,120	110,120	22
23	V		19	Admin Consulting,Other		Provena Health Services	100.00%	325,324	325,324	23
24	V		17	Information Systems Salaries	100,884	Provena Health Services	100.00%	19,374	(81,510)	24
25	V		22	Information Systems Benefits		Provena Health Services	100.00%	7,103	7,103	25
26	V		6	Information Systems - Equip Maint		Provena Health Services	100.00%	9,487	9,487	26
27	V		17	Admin Salaries		Provena Health Services	100.00%	57,366	57,366	27
28	V		22	Employee Benefits		Provena Health Services	100.00%	20,783	20,783	28
29	V		17	Information Systems Salaries		Provena Health Services	100.00%	30,613	30,613	29
30	V		22	Information Systems Benefits		Provena Health Services	100.00%	11,090	11,090	30
31	V		6	Information Systems - Equip Maint		Provena Health Services	100.00%	40,637	40,637	31
32	V		39	Ancillary Services - Other	795,439	Provena Senior Services Pharmacy	100.00%	795,439		32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 1,042,363			$ 1,867,391	$ * 825,028	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number PROVENA VILLA FRANCISCAN # 0042861 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PROVENA VILLA FRANCISCAN # 0042861 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Senior Services
Street Address: 19065 Hickory Creek Drive, Ste 310
City / State / Zip Code: Mokena, IL60448
Phone Number: (708)478-7900
Fax Number: (708)478-5387

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Management Fee Income	4,942,944	16	$ 22,950	$	592,323	$ 2,750	1
2	5	Utilities	Management Fee Income	4,942,944	16	11,646		592,323	1,396	2
3	6	Maintenance - Other	Management Fee Income	4,942,944	16	4,154		592,323	498	3
4	11	Activities-Special Events	Management Fee Income	4,942,944	16	20,442		592,323	2,450	4
5	17	Admin - Misc. Other	Management Fee Income	4,942,944	16	48,582		592,323	5,822	5
6	17	Administrative Salaries	Management Fee Income	4,942,944	16	1,617,398	1,617,398	592,323	193,816	6
7	19	Professional Services	Management Fee Income	4,942,944	16	311,867		592,323	37,372	7
8	20	Dues,Subscriptions	Management Fee Income	4,942,944	16	191,638		592,323	22,964	8
9	21	Clerical Supplies	Management Fee Income	4,942,944	16	102,640		592,323	12,300	9
10	22	Employee Benefits	Management Fee Income	4,942,944	16	496,473		592,323	59,493	10
11	23	Education/Conference	Management Fee Income	4,942,944	16	76,847		592,323	9,209	11
12	24	Travel	Management Fee Income	4,942,944	16	67,676		592,323	8,110	12
13	26	Insurance	Management Fee Income	4,942,944	16	75,628		592,323	9,063	13
14	27	Bad Debt	Management Fee Income	4,942,944	16	560,691		592,323	67,189	14
15	30	Depreciation	Management Fee Income	4,942,944	16	30,542		592,323	3,660	15
16	32	Interest	Management Fee Income	4,942,944	16	1,840,794		592,323	220,586	16
17	34	Rent - Facility	Management Fee Income	4,942,944	16	149,043		592,323	17,860	17
18	35	Rent - Equipment	Management Fee Income	4,942,944	16	15,101		592,323	1,810	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,644,112	$ 1,617,398		$ 676,348	25

Facility Name & ID Number PROVENA VILLA FRANCISCAN # 0042861 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Health Services
Street Address: 9223 West St. Francis Road
City / State / Zip Code: Frankfort, IL 60423
Phone Number: (815)469-4888
Fax Number: (815)469-4864

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Admin Salaries	Operating Expense	1,101,876		$ 714,188	$ 714,188	146,040	$ 94,657	1
2	22	Employee Benefits	Operating Expense	1,101,876		258,738		146,040	34,293	2
3	30	Depreciation	Operating Expense	1,101,876		830,857		146,040	110,120	3
4	19	Admin Consulting,Other	Operating Expense	1,101,876		2,454,578		146,040	325,324	4
5	17	Information Systems Salaries	Operating Expense	761,172		146,180	146,180	100,884	19,374	5
6	22	Information Systems Benefits	Operating Expense	761,172		53,593		100,884	7,103	6
7	6	Information Systems - Equip Mair	Operating Expense	761,172		71,577		100,884	9,487	7
8	17	Admin Salaries	Direct Cost	1,101,876		432,829	432,829	146,040	57,366	8
9	22	Employee Benefits	Direct Cost	1,101,876		156,806		146,040	20,783	9
10	17	Information Systems Salaries	Direct Cost	761,172		230,974	230,974	100,884	30,613	10
11	22	Information Systems Benefits	Direct Cost	761,172		83,678		100,884	11,090	11
12	6	Information Systems - Equip Mair	Direct Cost	761,172		306,605		100,884	40,637	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,740,603	$ 1,524,171		$ 760,847	25

Facility Name & ID Number PROVENA VILLA FRANCISCAN # 0042861 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Senior Services Pharmacy
Street Address: 1475 Harvard Drive
City / State / Zip Code: Kankakee, IL 60901
Phone Number: (815)928-6141
Fax Number: (815)946-3238

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Cost			$	$		$ 795,439	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 795,439	25

Facility Name & ID Number PROVENA VILLA FRANCISCAN # 0042861 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	Provena Senior Services										212,175	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 212,175	14
15	TOTALS (line 9+line14)						$	$			$ 212,175	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number PROVENA VILLA FRANCISCAN # 0042861 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PROVENA VILLA FRANCISCAN COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0042861

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number PROVENA VILLA FRANCISCAN # 0042861 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 70,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO

If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		1990	$ 285,994	1
2					2
3	TOTALS			$ 285,994	3

Facility Name & ID Number PROVENA VILLA FRANCISCAN # 0042861 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	176		1990	1990	$ 606,931	$ 219,653	15	$ 219,653	$	$ 3,995,393	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	DESC: KEYPAD ALARM SYSTEM			2004	3,926	196	10	393	196	393	9
10	DESC: CARPET REPLACEMENT			2004	6,251	625	5	1,250	625	1,250	10
11	DESC: FIRE DAMPER			2004	1,389	46	15	93	46	93	11
12	DESC: REPAVING OF PARKING LOT			2004	1,023	64	8	128	64	128	12
13	DESC: REPAVING PARKING LOT			2004	10,964	685	8	1,370	685	1,370	13
14	DESC: ELECTRIC PNEUMA			2004	1,900	190	5	380	190	380	14
15	DESC: NORLAKE OUTDOOR WALK-IN COOLER/FREEZ			2004	32,585	1,086	15	2,172	1,086	2,172	15
16	DESC: FURNISH AND INSTALL (4) GE 90 AMP CO			2004	1,691	85	10	169	85	169	16
17	DESC: CUBICLE TRACKS AND CURTAINS			2004	11,808	295	20	590	295	590	17
18	DESC: DIVERTING RELAY, MODULAR GASKET, SOC			2004	2,426	152	8	303	152	303	18
19	DESC: INSTALLATION OF 12 ISOLATIONS VALVES			2004	13,395	447	15	893	447	893	19
20	DESC: SIXTY CU/FT OF SST-60 SALT SAVING TE			2004	9,950	332	15	663	332	663	20
21											21
22	DESC: CCTV			2003	3,910	782	5	782		1,173	22
23	DESC: STAINED GLASS WINDOW FOR CHAPEL			2003	1,575	158	10	158		236	23
24	DESC: MURAL DAMIANO UNIT			2003	1,850	370	5	370		555	24
25	DESC: MURAL			2003	3,000	600	5	600		900	25
26	DESC: MCQUAY COMPRESSOR FOR KITCHEN UNIT			2003	3,629	302	12	302	(0)	454	26
27	DESC: ALARM SYSTEM			2003	3,860	386	10	386		579	27
28	DESC: REPAIR REACH-IN FREEZER			2003	2,764	276	10	276	0	415	28
29	DESC: SECURITY SYSTEM			2003	3,390	339	10	339		509	29
30	DESC: WANDER GUARD SYSTEM			2003	1,853	124	15	124	0	185	30
31	DESC: RELIEF VALVE FOR REFRIGERATION SYSTE			2003	2,735	391	7	391	0	586	31
32	DESC: SELONOID FOR HOT WATER TANK			2003	985	99	10	99		148	32
33	DESC: WINDOW TREATMENT FOR VENETIAN LOUNGE			2003	1,296	259	5	259	(0)	259	33
34	DESC: LAMINATION OF VENETIAN NURSES STATIO			2003	5,201	347	15	347	(0)	347	34
35	DESC: CERAMIC FLOOR TILE			2003	1,387	69	20	69	0	69	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number PROVENA VILLA FRANCISCAN # 0042861 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38	DESC: GARBAGE DISPOSAL	2002	875	175	5	175		438	38
39	DESC: CARPET FOR ELEVATORS	2002	1,831	366	5	366		732	39
40	DESC: ACCESS CONTROL TO FIRE ALARM	2002	3,150	315	10	315		788	40
41	DESC: INSTALLATION OF DOME CAMERA	2002	2,346	469	5	469		1,173	41
42									42
43	DESC: RELOCATE NURSE CALL SYSTEM	2001	2,576	515	5	515		1,803	43
44	DESC: CARPET	2001	1,565	313	5	313		1,096	44
45	DESC: CONVEYOR TOASTER	2001	590	118	5	118		413	45
46	DESC: RESIDENT ROOM DOOR CLOSER	2001	1,255	251	5	251		879	46
47	DESC: REPLACE 3 GAS SHUT OFF VAVLES	2001	989	198	5	198		692	47
48	DESC: CARPET	2001	3,298	660	5	660		2,308	48
49	DESC: DRIVEWAY, BLACKTOPPING	2001	2,900		2			2,900	49
50									50
51	BUILDING IMPROVEMENTS	2000	73,038	11,027	7	11,027		49,623	51
52	BUILDING IMPROVEMENTS	1999	4,936	676	7	676		4,024	52
53	BUILDING IMPROVEMENTS	1998	21,439		5			21,439	53
54	BUILDING IMPROVEMENTS	1997	18,743	1,105	9	1,105		13,813	54
55	BUILDING IMPROVEMENTS	1996	45,626	2,391	10	2,391		32,431	55
56	BUILDING IMPROVEMENTS	1995	80,456	3,330	16	3,330		34,535	56
57	BUILDING IMPROVEMENTS	1994	32,574	1,722	19	1,722		19,636	57
58	BUILDING IMPROVEMENTS	1993	28,123	1,185	18	1,185		18,261	58
59	BUILDING IMPROVEMENTS	1992	57,831	2,666	18	2,666		37,644	59
60	BUILDING IMPROVEMENTS	1991	2,510	126	20	126		1,590	60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,128,325	$ 255,965		$ 260,167	$ 4,203	$ 4,256,432	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA VILLA FRANCISCAN # 0042861 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 835,654	$ 79,246	$ 79,246	$	12	$ 575,204	71
72	Current Year Purchases	176,500	10,787	18,955	8,167	9	18,955	72
73	Fully Depreciated Assets	435,996					435,996	73
74	Home Office Allocation			113,780	113,780			74
75	TOTALS	$ 1,448,149	$ 90,033	$ 211,980	$ 121,947		$ 1,030,154	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,862,469	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 345,997	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 472,147	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 126,150	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,286,586	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocation - Home Office				17,860			5
6								6
7	TOTAL				$ 17,860 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [x] NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 74,421 Description: Nursing - $71,511.67, Activities - $675.54, Maint - $(3,494.31), Admin - $3,918.13, Home Office - $1,810
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PROVENA VILLA FRANCISCAN # 0042861 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 3	hrs	$	4,339	$ 226,493	$	4,339	$ 226,493	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		1,153	60,210		1,153	60,210	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		4,590	239,594		4,590	239,594	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				795,439		795,439	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	10,082	$ 526,296	$ 795,439	10,082	$ 1,321,735	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number PROVENA VILLA FRANCISCAN **#** 0042861 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 8,885,741	$	1
2	Cash-Patient Deposits	102,693		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	8,420,236		3
4	Supply Inventory (priced at)	588,898		4
5	Short-Term Investments			5
6	Prepaid Insurance	7,152		6
7	Other Prepaid Expenses	124,516		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 18,129,236	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,836,704		12
13	Land	6,851,272		13
14	Buildings, at Historical Cost	74,980,161		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	13,506,539		16
17	Accumulated Depreciation (book methods)	(40,776,212)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Goodwill	140,712		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 62,539,176	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 80,668,412	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,746,542	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,611,167		28
29	Short-Term Notes Payable	31,980		29
30	Accrued Salaries Payable	1,849,317		30
31	Accrued Taxes Payable (excluding real estate taxes)	44,053		31
32	Accrued Real Estate Taxes(Sch.IX-B)	240,643		32
33	Accrued Interest Payable	23,513		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Party	988,855		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,536,070	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,363,410		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	143,623		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,507,033	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,043,103	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 72,625,309	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 80,668,412	$	48

***(See instructions.)**

Facility Name & ID Number PROVENA VILLA FRANCISCAN # 0042861 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 31,464,506	1
2	Restatements (describe):		2
3			3
4	**Adj. To Reconcile Consolidated Equity and Consolidated**		4
5	**Net Income to Nursing Facility Amounts**	833,949	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 32,298,455	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(279,472)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (279,472)	17
	B. Transfers (Itemize):		
18	**Transfer Debt to Provena Health**	40,606,326	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 40,606,326	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 72,625,309	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number PROVENA VILLA FRANCISCAN # 0042861 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,167,908	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,167,908	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,184,627	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,184,627	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	14,225	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	869,374	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	49,031	20
21	Other Medical Services		21
22	Laundry	33,610	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 966,240	23
	D. Non-Operating Revenue		
24	Contributions	12,575	24
25	Interest and Other Investment Income***	8,411	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 20,986	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates	18,342	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 18,342	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,358,103	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,580,581	31
32	Health Care	5,006,395	32
33	General Administration	2,732,343	33
	B. Capital Expense		
34	Ownership	426,193	34
	C. Ancillary Expense		
35	Special Cost Centers	795,439	35
36	Provider Participation Fee	96,624	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,637,575	40
41	**Income before Income Taxes (line 30 minus line 40)****	(279,472)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (279,472)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PROVENA VILLA FRANCISCAN # 0042861 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,164	2,437	$ 78,591	$ 32.25	1
2	Assistant Director of Nursing	1,461	1,681	44,288	26.35	2
3	Registered Nurses	25,460	26,524	706,500	26.64	3
4	Licensed Practical Nurses	46,064	49,802	947,592	19.03	4
5	Nurse Aides & Orderlies	128,365	136,968	1,571,197	11.47	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,850	6,421	76,102	11.85	8
9	Activity Director	1,957	2,160	41,225	19.09	9
10	Activity Assistants	10,245	11,126	106,220	9.55	10
11	Social Service Workers	6,298	6,907	87,928	12.73	11
12	Dietician	2,096	2,320	40,442	17.43	12
13	Food Service Supervisor	1,440	1,601	19,082	11.92	13
14	Head Cook	7,254	7,841	73,050	9.32	14
15	Cook Helpers/Assistants	25,507	27,510	219,877	7.99	15
16	Dishwashers					16
17	Maintenance Workers	9,815	11,005	145,413	13.21	17
18	Housekeepers	18,405	19,847	173,128	8.72	18
19	Laundry	4,835	5,467	47,355	8.66	19
20	Administrator	1,912	2,160	84,479	39.11	20
21	Assistant Administrator	1,852	2,020	57,118	28.28	21
22	Other Administrative	5,067	5,435	82,114	15.11	22
23	Office Manager					23
24	Clerical	6,757	7,320	89,288	12.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Pastoral/Developm	2,812	3,092	49,225	15.92	33
34	TOTAL (lines 1 - 33)	315,616	339,644	$ 4,740,214 *	$ 13.96	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	591	$ 30,762	1,3	35
36	Medical Director	$1100/mth	22,704	9,3	36
37	Medical Records Consultant	24	1,050	10,3	37
38	Nurse Consultant	253	12,655	10,3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	18	876	11,3	44
45	Social Service Consultant	10	595	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	896	$ 68,642		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	721	$ 31,669	10,3	50
51	Licensed Practical Nurses	740	29,330	10,3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,461	$ 60,999		53

Facility Name & ID Number PROVENA VILLA FRANCISCAN # 0042861 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ann Dodge	Administrator	0	$ 84,479
Administrative Staff	Admissions	0	31,022
Administrative Staff	Bookkeeper	0	57,163
Administrative Staff	Receptionist	0	48,031
Administrative Staff	Admin Asst	0	35,186
Administrative Staff	Asst Administrator	0	57,118
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 312,999

B. Administrative - Other

Description	Amount
Corporate Service Fee	$ 146,040
Corporate IS Fee	100,884
Mgmt Fee	436,323
Mgmt Fee Interest	156,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 839,247
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal Expense	Various	$ 65,057
Wellspring/BKD Expense	Various	19,355
Collection Expense	Various	0
Employee Opinoin Survey	Various	1,998
Shredding	Various	1,129
Medical Records	Various	6,029
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 93,568

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 87,023
Unemployment Compensation Insurance	32,361
FICA Taxes	342,518
Employee Health Insurance	442,504
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	18,364
Pension	168,106
Employee Recognition	0
Executive Benefits	9,609
Employment Screenings	11,146
Home Office Allocation	131,683
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,243,314

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 132)	
Dues & Subscriptions	12,162
Advertising & Public Relations	43,689
Home Office Allocation	22,964
Less: Public Relations Expense	( )
Non-allowable advertising	(8,351)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 70,464

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	6,715
See Schedule	
Home Office Allocation	8,110
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,825

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PROVENA VILLA FRANCISCAN # 0042861 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number PROVENA VILLA FRANCISCAN **#** 0042861 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **7219 - Life Services Network**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **Yes** If YES, what is the capacity? **176**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **26,343** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **96,624**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **N/A**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not issued yet**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.